TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Orthotexas Physician

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-2287-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On this date of service, CPT A9999 rejected for "claim/service lacking information needed for adjudication." See attached dictation that supports the services rendered. Please process this claim for payment immediately."

Amount in Dispute: $175.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Miscellaneous DME CPT Code A9999 requires the submission of a manufacturer's invoice."

Response Submitted by: ESIS Bill Review, 1851 E 1st St #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 19, 2016	A9999	$175.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.1(f) which details medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Please identify the supply and submit with a copy of the invoice for our review

- 16 – Claim/service lacks information or has submission/billing error (s) which is needed for adjudication
- 1 – Original DCN 34417778
- 2 – This procedure on this date was previously reviewed
- 18 – Duplicate claim/service

Issues

1. What is the applicable fee rule?
2. Did the requestor provide documentation to support requested payment amount?

Findings

1. The requester seeks additional reimbursement in the amount of $175.00 for code A9999.

   The carrier reduced the payment with the following reason codes 16 – "Claim/service lacks information or has submission/billing error (s) which is needed for adjudication

   The service in dispute is durable medical equipment which are subject to 28 Texas Administrative Code 134.203(d)(3) which states,

   The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
   >
   > (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
   >
   > (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

   Review of the applicable DMEPOS fee schedule finds no fee schedule amount for A9999.

   Review of the Texas Medicaid fee schedule finds no fee schedule amount for A9999.

   The service in dispute will be reviewed pursuant to 28 Texas Administrative Code §134.203(f) which states,

   > For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

2. The division concluded above that §134.1(f) applies and states,

   Fair and reasonable reimbursement shall:

   > (1) be consistent with the criteria of Labor Code §413.011;
   > (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   > (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

   For that reason, 28 Texas Administrative Code §133.307(c)(2)(O) also applies and, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

Review of the submitted documentation finds:

- The requestor does not discuss or demonstrate how reimbursement of $175.00 for code A9999 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1(f).

For the reasons stated, the division concludes that the requestor failed to support its request for reimbursement. For that reason, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		April 21, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.